

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41052

State File No. \_\_\_\_\_

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4262

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: General Hospital #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution less than 1 day  
In this community 50 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Louis Wilson

3. (b) If veteran, name war None 3. (c) Social Security No. 495-05-4056

4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jaunita Wilson 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased: August 24, 1885  
(Month) (Day) (Year)

8. AGE: Years 56 Months 3 Days 22 If less than one day hr. min.

9. Birthplace Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Packer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Jack Wilson  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Jaunita Wilson

(b) Address 5902 East 35th Terr.

17. (a) burial (b) Date thereof 12/20/41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
Highland Cemetery

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Hatkins Bros

(b) Address 1729 Lydia

19. 12-19-41 (b) M. M. Grove  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5902 East 35th Terr.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 16 year 1941 hour 4 minute 30 M.

21. I hereby certify that deceased died from Spontaneous cerebral hemorrhage  
that I personally attended on 12-16-41 to 4:30 A.  
and that death occurred on the date and hour stated above.

Immediate cause of death Spontaneous cerebral hemorrhage  
Due to Hypertensive heart disease  
Due to \_\_\_\_\_

Other conditions 430  
(Include pregnancy within 3 months of death)

Major findings: 430  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of injury)  
23. Signature M. M. Grove (M. D. or other) \_\_\_\_\_  
Address 14-C No Date signed \_\_\_\_\_

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*B. L. Graham*

Licensed Embalmer No. *2540*

P. O. Address *2208 Vine St*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**